April 30, 2003

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-0794-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___is a 33-year-old truck driver who was involved in a truck accident in which his vehicle slipped over onto its side. He sustained injury to his lower back in this accident. He complained of low back pain with radiation into the back of the right hip and down the right leg to the foot. He had muscle spasm and was not able to return to work. He was treated b a chiropractor. He also had physical therapy and an exercise program, but he did not respond to these treatments. He went through a series of lumbar epidural steroid injectiosn and a work h ardening program and still did not improve enough to return to work. He was referred by the chiropractor to ___, a spine surgeon, who suggested discograms and probable surgery on his back. The patient then had an MRI of his back that demonstrated only disc desiccation at the L4/5 level and the L/S1 level. There was some mild posterior bulging reported on the MRI. Discograms done on February 1, 2002 by ___ were basically normal. At L4/5, a discordant pain was produced in the thigh and the discogram demonstrated only a 2 m posterior central bulge of the disc. At the L5/S1 level there was no pain produced at all, and there was no posterior annular tear, but there was an anterior annular tear contained in the front.

The discogram is therefore negative for concordant pain at both the L4/5 and L5/S1 levels. This patient has been seen and treated by ___ who has requested approval for IDET procedure at the L4/5 level.

REQUESTED SERVICE

An outpatient IDET procedure is requested for this patient.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

The reviewer finds that the IDET procedure at L4/5 is not indicated in this case. The rationale for this is as follows: The discogram that was done on February 1, 2002 by ___was basically normal with regards to the production of concordant pain. There was no concordant pain produced by this discogram and there was no annular tear at the L4/5 level. In fact, no tear was reported at all, and only a 2 mm bulge posteriorly was reported on the discogram. Therefore, with a negative discogram, the reviewer does not recommend the L4/5 IDET procedure.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of

Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).